ATTESTATION
Psych Under 21 Rule

Use of restraint and seclusion in psychiatric residential treatment facilities providing psychiatric services to individuals under age 21

Facility _____

Mailing Address_____

Physical Address of Facility if different than above_____

City _____ State _____ Zip Code _____

Telephone # _____ Fax # _____

Electronic Mail Address _____

Medical Assistance Provider #_____

National Provider Identification (NPI) # _____

Total Number of Facility Beds _____

Number of Medicaid residents in Facility _____

Number of residents for whom the Psych Under 21 benefit is paid for by another state_____

Please list all states from whom your facility has ever received Medicaid payment for the provision of the Psych Under 21 benefit. _____
_____
_____

Attestations: (Must be signed by an individual who has the legal authority to obligate the facility.)

_____ being first duly sworn on oath states and alleges as follows:
Name / Title

A reasonable review has been conducted in the facility. Based on my best knowledge, information, belief, and reasonable interpretation and understanding of the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21, (published on January 22, 2001, and amended with the publication of May 22, 2001) on behalf of the facility, I hereby attest that the facility complies with all of the requirements set out in that regulation as codified at 42 CFR §§483 Subpart G.

I understand the Centers for Medicare and Medicaid Services, the State of South Dakota Survey Agency or their representatives may survey the facility at any time to determine compliance with the requirements, investigate complaints lodged against the facility or to investigate serious occurrences as set forth in the Condition of Participation as established by the interim final rule in accordance with and to the extent authorized by 42 CFR §431.610.

In addition, I agree to submit a new attestation of compliance annually and I will notify the State of South Dakota Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor.

Dated this _____ day of _____, at _____

Signature & Title of Owner/Administrator _____

Subscribed and sworn to before me this _____ day of _____

My Commission expires _____ _____
Notary Public